

Three Mile Island Alert (TMIA) moves the Licensing Board to require further development of the record on the issue of Licensee's management response to the TMI-2 accident.

The evidentiary record on all management issues is closed. The Board has permitted into the record only one full investigation examining the reporting of information during the TMI-2 accident, that being the NRC's Office of Inspection and Enforcement (IE) investigation, NUREG-0760, Staff Ex. 5. IE's conclusions can be summarized as follows:

This investigation found that although pertinent information was not intentionally withheld on March 28, 1979, information was not adequately transmitted to the NRC or the Bureau of Radiological Protection. The investigators concluded that two primary factors examined during the investigation caused the failure of station personnel to adequately inform the necessary organizations. The predominent factor was the absence of an effective onsite system to accumulate, evaluate, and disseminate information. The second factor was the lack of comprehension by plant personnel of the behavior of the plant system.Staff Ex. 5, at 10.

The Board has recognized, however, that there exists another investigation into the reporting of information during the TMI-2 accident, that report produced by the Majority Staff of the Committee on Interior and Insular Affairs of the U.S. House of Pepresentatives, 97th Congress, 1st Session. (Udall). This report

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examines essentially the same raw material as IE's investigation, and also concludes that information was not adequately transmitted to State and Federal officials. However, this report attributes the reporting failure not to merely ineffective onsite information systems, and lack of comprehension by onsite personnel, but rather to a willful withholding of information by TMIA managers. The Udall report concludes:

TMI managers did not communicated information in their possession that they understood to be related of the severity of the situation... In addition, the record indicates that that TMI managers presented State and Federal officials misleading statement (i.e. statements that were inaccurate and incomplete), that conveyed the impression the accident was substantially less severe and the situation more under control than what the managers themselves believed and what was infact the case.

While permitting this conclusion into the record, the supporting document was not admitted. The Board indicated that since both reports examined the same basic material, which was already part of the record in the context of the IE investigation, admitting the entire contents of the Udall report would be repetitious. In other words, whatever benefit could be derived from having in the record Udall's analysis of that evidence, leading to the more damaging , conclusion, was outweighed by the necessity to keep the massive record free from repetitious material. We can reasonably infer that the Board believed the two views, one expounded and consistently supported on the record by the NRC and one expounded by the Congressional Committee, were properly balanced on the record. The fact that Udali's analysis and interpretation was ommitted from the record did not disturb this equipoise.

We should next examine the significance of accepting one or the other\_conclusion. The importance rests in the Board's view of the adequacy of the steps Licensee has allegedly taken to remedy

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deficiencies in its corporate management structure which the TMI-2 accident revealed. Licensee alleges that its corporate and management structure do not reveal deficiencies that have not yet been corrected which must be corrected before Unit 1 can be operated safely. Should the Board accept IE's interpretation that the reporting failures were essentially structural and/or training problems, Licensee could reasonably remedy such problems by changing the structure of their onsite information system, and/or their emergency training programs. However, if the Board accepts Udall's conclusion of an intentional, willful withholding of information by managers in a direct allempt to mislead State and Federal officials. such problems could only be solved, if at all, by removal of those individuals who participated directly in the deceit, and those who encouraged or supported it. Thus, the significance of the two conclusions relates directly to whether Licensee has taken sufficient steps to cure past management problems revealed by the TMI-2 accident.

On June 4, 1981, after the record on management issues closed, the NRC's Advisory Committee on Reactor Safeguards (ACRS) published a paper prepared by Mr. Edward C. Abbott, ACRS Senior Fellow, which reviews the Udall report. TMIA received a copy of this report and memorandum on June 19, 1981. (Attachment A). The ACRS report concludes that :

Based on my review of the Staff Report, additional information presented in section four and my previous experience as an operations supervisor, I agree with the conclusion presented in the Udall Report. The Staff's conclusion is contrary to other investigations conducted by the NRC. In addition, the plant's operating procedures were follows but were inadequate while the site's emergency plan and procedures were adequate but not followed. The former led directly to a degraded core and the latter left state and public officials inadequately informed.

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Thus, an express divergence of opinion within the NRC itself on this issue is now clearly evident. If nothing else, the credibility of the IE analysis and conclusions is now severly weakened and that of the Udall report is strengthened, thus significantly shifting the balance and thus the weight which the Board should afford both these reports. The ACRS report lends strong support to the proposition that the IE analysis is faulty and therefore its conclusion is wrong.

Thus, TMIA maintains that it is unconscionable for the Board to permit only IE's interpretation of the evidence, found in pages 12-52 of Staff Ex. 5, as part of the record. The purpose of this hearing is to fully develop all relevant facts necessary to reach a correct conclusion on whether Licensee has corrected all deficiencies revealed by the TMI-2 accident so as to be able to operate TMI-1 safely. While the Board will determine in its discretion the weight to be afforded given particular facts, it must at least consider all the relevant evidence. See support for this proposition, e.g., in Office of Communication of the United Church of Christ v. FCC, 425 F.2d 543 (D.C. Cir., 1969); Scenic Hudson Preservation Conference v. Federal Power Commission, 354 F.2d 608 (2d Cir., 1965). Without the full Udall report in evidence, the Board will be unable to properly evaluate, and therefore afford the proper weight to the Udall conclusion, since it will not be presented to the Board in the context of the Staff's analysis and interpretation. And since it is an analysis and conclusion with support within the NRC itself, TMIA believes the Board has a duty to afford this document substantial weight.

For the foregoing reasons, therefore, TMIA moves the Board

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to remedy the deficiencies in the record on the issue of management's response to the TMI-2 accident, by ordering the Udall report into evidence. In addition, TMIA moves that the ACRS report be admitted for the purpose of supporting the Udal! conclusion, or in the alternative, for the purpose of showing a difference of opinion within the NRC as to reporting failures during the TMI-2 accident.